Physician Request Form for Patient Self-Administered Injectable and Specialty Drugs

Fax to Pharmacy Services at **855-811-9332**, or call **888-602-3741**
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas
District of Columbia

Patient Name: _____ Patient ID #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Height: _____ Weight: _____lbs = _____Kg Birth Date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

To be administered from: _____to _____ or on:_____

Drug Name (**see below**):_____

Sig (How Administered): _____ Diagnosis: _____

Justification for Drug Use (Add Attachment if Necessary):_____

_____

Anticoagulants	**Strength**
Heparin Sodium Does Not Require Prior Authorization	
Heparin Sodium	
Dose:_____Sig:_____	
Anticoagulants	**Strength**
Fragmin	2,500U/0.2ml
Fragmin	5,000U/0.2ml
Fragmin	7,500U/0.3ml
Fragmin	10,000U/1ml
Fragmin	2,500U/Ml
Fragmin	10,000U/Ml
Lovenox	30mg/0.3ml
Lovenox	40mg/0.4ml
Lovenox	60mg/0.6ml
Lovenox	80mg/0.8ml
Lovenox	100mg/1ml
Lovenox	120mg/0.8ml
Lovenox	150mg/1ml
Lovenox	100mg/1ml
Arixtra	2.5mg/0.5ml
Arixtra	5mg/0.4ml
Arixtra	7.5mg/0.6ml
Arixtra	10mg/0.8ml
Dicyclomine	10mg/Ml

Hormones	**Strength**
Depo-Testosterone	100 Mg/Ml
Depo-Testosterone	200 Mg/Ml
Depo-Estradiol	5 Mg/Ml
Pulmonary Drugs	**Strength**
Pulmozyme	1 Mg/Ml
Tobi	300mg/5ml
Multiple Sclerosis Treatments	**Strength**
Indicate Type Of Ms	
□ **Relapsing Remitting**	
□ **Secondary Progressive With Relapses**	
□ **Primary Progressive**	
Copaxone	20 MG/ML
Copaxone	40 MG/ML
Avonex Prefilled Syr	30mcg/.5ml
Avonex Prefilled Syr Kit	30mcg/.5ml
Avonex Admin Pack	30 Mcg
Avonex Pen	30mcg/.5ml
Avonex Pen Kit	30mcg/.5ml
Miscellaneous	**Strength**
Cyanocobalamin Does Not Require Prior Authorization	
Cyanocobalamin	1000mcg/Ml
Other (Write In):	

- Avonex, Copaxone, Hormones, and Pulmozyme: initial 30 days supply & 5 refills allowed. All other medications must be requested monthly.

Physician Signature: _____ Date: _____

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